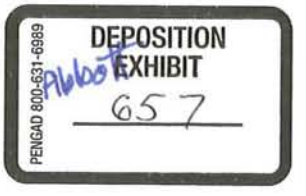
EXHIBIT 158

MEDICAID PHARMACY PAYMENTS
ACTUAL ACQUISITION COST & ESTIMATED ACQUISITION COST

Prepared by the Department of Social Services (March 1994)



INTRODUCTION

This report responds to requirements from Public Act 186 of 1993, Section 920, which states:

(1) No later than March 30, 1994, the department shall provide to the members of senate and house appropriations subcommittees on social services and their respective fiscal agencies a report outlining the various aspects of the current pharmaceutical product reimbursement methodology as compared to reimbursement based on an estimated acquisition cost methodology.

(2) This report shall be of sufficient detail to allow the subcommittees to determine the need for and specifications of a new pharmaceutical reimbursement methodology.

EXECUTIVE SUMMARY

If Medicaid were to consider Estimated Acquisition Cost (EAC), the department recommends that implementation be budget neutral. However, the cost evaluation of changing policy is difficult at this time, because the department is in the middle of converting its 4,200 Michigan Medicaid drug codes to over 60,000 National Drug Codes (NDCs). Studies based on the 4,200 current codes would be inaccurate and misleading. An EAC system could be accomplished only after full NDC implementation and sufficient NDC data can be collected to evaluate the budgetary impact. NDC conversion is targeted for the first quarter of FY-95. Therefore, July 1, 1995 is the earliest date any EAC system could be implemented.

DISCUSSION TOPICS

In fulfilling these requirements, the Department of Social Services will discuss the following topics.

BACKGROUND

Pharmacy Payments

Attachments 1 and 2 provide a ten year trend of Medicaid pharmacy payments from FY-84 to FY-93 and pharmacy payments by product type (e.g., generic, sole-source, etc.) for October 1992. The following points highlight observations from these charts and other pertinent trends.

- In FY-93, Medicaid processed 13 million prescriptions and paid pharmacies $265 M.
- Product charges are now 84% of total pharmacy charges with the remaining amount for fees.
- During 1993, Medicaid billed $54 M in manufacturer rebates mandated by federal law.
- In the last ten years, pharmacy payments per recipient have increased 82%.
- During FY-91 and -92 inflation was slowed by implementing manufacturer rebates, prior approval for multi-source brandname drugs, and increasing copays to $1 from $0.50 — but FY-93 showed a 9% increase in the costs for recipient.
- Multi-source drugs are 35% of the pharmacy payments but 62% of the prescriptions.
- Sole-source drugs are 60% of the pharmacy payments but only 30% of the prescriptions.
- The average pharmacy claim is paid in 10 days after Medicaid receives it.

National Drug Code (NDC) Conversion

In 1991, federal drug rebate guidelines required implementation of NDCs. Accordingly, staff has been converting our drug codes to NDCs. NDC conversion included implementation of a relational database in March 1994. This new subsystem offers tremendous monitoring capabilities and eliminates manual pricing bridges. Next, invoice processing logic and reporting subsystems will be updated to incorporate the added features of the relational database. Since Medicaid processes 13 million prescriptions a year, small glitches in NDC conversion could cause payment problems for hundreds of thousands of claims. Accordingly, testing will be detailed and time-consuming. NDC conversion will be implemented during the first quarter of FY-95.

By July 1, 1993 all pharmacy invoices identified both a 7-digit Medicaid drug code and an 11-digit NDC. The Medicaid drug code is used pricing and reporting. The NDCs are carried only into a special rebate sub-system. This tactic saved us staffing resources for other system mandates without ignoring the federal NDC requirement.

Among other advantages, NDC conversion will provide greater precision in approximating pharmacy costs. There are nearly 4,200 Medicaid drug codes currently used for pricing. On the other hand, there are about 60,000 NDCs for our 4,200 codes. This difference occurs because:

- An NDC is set for every manufacturer by purchase size (e.g., bottles of 100s, 250s, etc.). Note: When package size increases, cost per unit decreases (similar to bulk purchases in the grocery store).
- But, only one Medicaid code is set for all purchase sizes of sole-source drugs and one code is used for multi-source generics regardless of how many manufacturers or package sizes exist.

REIMBURSEMENT METHODS

Actual Acquisition Cost (AAC), Current Medicaid Reimbursement
AAC is payment at the *actual invoice cost* for a drug product to the pharmacy (or its company, organization, corporation, or affiliate). Except for a 2% allowance for cash discounts, actual acquisition cost must reflect trade and quantity discounts, rebates, free goods, and price concessions. AAC is the current method of Medicaid payment for drug product costs.

AAC Drug Payment Screens
Medicaid reviews the appropriateness of product charges with predetermined standards called pricing screens. Each screen corresponds to one of the 4,200 Medicaid drug codes. Unless specified on the table below, screens are set at Average Wholesale Price Discounted 10% (AWP-10%) for the container size typically bought by pharmacies. Since AWP changes frequently based on manufacturer increases, Medicaid drug screens are reviewed twice a month through a computer data exchange. This computer system includes formulas for screen calculation and a bridge to link a Medicaid drug code to one of the 60,000 National Drug Codes (NDCs).

In the 70s and early 80s, the department used screens set at AWP without discounts. However, starting in 1987, drug screens were set to mimic the purchasing power available for small independent pharmacies. This change did not affect pharmacy Medicaid participation. (Note: Currently, most pharmacies licensed in the state are participating with Medicaid.) Medicaid drug screens approximate pharmacy purchase costs. However, since pharmacies are paid on their actual acquisition costs, these screens are not guaranteed payments or mandatory charge levels.

In summary, Medicaid's drug screens reflect (1) the purchasing power of small independent pharmacies; (2) product type discounts, e.g., sole-source, multi-source drugs, etc.; and (3) pricing practices of manufacturers and wholesalers.

Michigan Medicaid AAC Screens

Drug Type	Price Base
DEA Scheduled II Drugs	Average Wholesale Price (AWP)
Misc. Supplies and Dietary Formulas	Estimated Retail Price
Drugs Made by Merck, Pfizer, & Upjohn	Manufacturer Direct Price
High Use, Multi-Source Equivalent Drugs	Maximum Allowable Cost (MAC) (federally mandated & revised to state purchase practices by pharmacies)
Other Drugs	Average Wholesale Price - 10% (AWP-10%)

Drug Cost Payment
Pharmacies are required to charge the lower of (1) *usual & customary charge* [as required by federal regulation at 42 CFR 447.331(b)(2)] or (2) *actual acquisition cost* plus their professional fee. Medicaid payment is the lower of the *actual acquisition cost* or *charge* or the Program's *screen*.

Estimated Acquisition Cost (EAC), Study Reimbursement

EAC is a pharmacy payment method when a third party payor or Medicaid program estimates the typical drug purchase costs and pays that estimated amount without further documentation of the pharmacist's actual costs. In other words, pharmacies are *guaranteed the EAC price regardless of the cost of the drug.*

EAC Drug Payment Screens

EAC reimbursement systems still use screens to review the appropriateness of product charges. The original goal of EAC was to set a screen based on the estimated procurement costs. EAC pricing screens can be based on a product type (similar to the current Medicaid actual acquisition cost). However, many payors use a common calculation for every drug billed. For example, Idaho Medicaid pays its pharmacies Average Wholesale Price (AWP) for any drug billed. (See Attachment 3 to review Methods Used by Other States.) Several EAC payors have established screens based on the size of the pharmacy. This pricing strategy assures that drug screens represent volume discounts that are available for larger pharmacies.

Because of federal regulations, Medicaid EAC payments cannot exceed a pharmacy's usual & customary charge to the general public. Most other payors do not have this limitation. EAC systems frequently use AWP in their payment calculation, but other national pricing standards are also employed. Following are typical EAC standards. (See the Glossary for more information on these.)

Summary of Typical EAC Screens

- Average Wholesale Price (AWP) minus a standard discount (ranging from 0% to as high as 17%)
- Maximum Allowable Cost (MAC) for multi-source generics
- Manufacturer Direct Price (Used on only selected manufacturers' products)
- Wholesale Acquisition Cost plus a standard markup (ranging from 7% to 12.5%)

EAC focuses on establishing screens at the lowest price that will maintain pharmacy participation regardless of the cost of the drug dispensed. The process of setting EAC screens is closely linked and balanced with setting dispensing fees. Payors are able to have low dispensing fee rates if they have high EAC screens. Particular attention must be given to setting EAC screens, since drug product costs are 84% of the pharmacy expenditures with only 16% for dispensing fees.

Some payors have implemented EAC systems, but update their rates once a quarter as a way to control cost increases. Since manufacturer price increases can occur any time during the year, pharmacy payments would be lower with this strategy.

Estimated Acquisition Cost	versus	Actual Acquisition Cost
Pricing screens are guaranteed payment up to usual & customary charge for Medicaid prescriptions.		Pricing screens are validity checks only. Actual acquisition costs are paid up to usual & customary or the Program's screen. Pharmacy charges must be actual invoice costs minus 2% for cash discounts.

IMPACTS OF CHANGING TO ESTIMATED ACQUISITION COST (EAC)

Recipients – No Impact

Medicaid has a high participation rate with pharmacies. There have been few access problems.

Department Staffing – No Reduction

EAC will not reduce department audit costs. Staff, also, will need to continue to review other programmatic concerns relating to fraud and abuse. Particular attention could be placed on pharmacies enhancing payments by billing a product under another's code. With staff not having to verify individual pharmacy's actual acquisition costs, it is believed that a greater number of audits will be able to be performed. (Last year nine pharmacy audits were done by the available staff). Staff resources for monitoring and updating EAC prices may need to be enhanced, since the EAC price would be much more critical than the current pricing method.

Legal – HCFA Approval Required

The legal agreement with the Health Care Financing Administration (HCFA) must be changed if EAC is implemented. As such, the federal government must approve any EAC system planned.

Medicaid Invoice Processing and Computer Systems

NDCs Needed for EAC. It is advisable that EAC be implemented using National Drug Codes (NDCs). NDCs provide pricing capabilities for every manufacturer's version of a drug, including separate NDC prices representing the savings available with bulk packages. Without this breakdown, increased costs could result. Medicaid will have NDCs fully implemented during first quarter of FY-95.

EAC May Require New Editing Logic. As mentioned before, EAC screens can be set on product type, manufacturer, and pharmacy size. Depending on the actual EAC system used, new editing logic may be needed in the invoice processing system. Because of the many NDC conversion changes, it would be advantageous for the department and pharmacies not to implement these projects simultaneously.

Cost Estimates

Since the department is in the middle of transition to NDCs, EAC cost studies based on the Medicaid drug code would be inaccurate and misleading. However, once data is available based on billings for NDCs, EAC prices can be established which can assure a cost neutral or cost saving policy change.

Provider Perspective with Medicaid Comments

Pharmacies have requested a change from AAC to EAC. Following are their reasons with Medicaid's comment.

IMPACTS OF CHANGING TO ESTIMATED ACQUISITION COST (continued)

Pharmacy Perspective — EAC will:	Medicaid Comment:
1. Reduce anxiety over Medicaid audits.	1. Medicaid audits will continue with EAC, although the focus will be on compliance and not an exact price of product.
2. Reduce complexities of billing and speed up payment.	2. Required billing data and payment time will not change with EAC. (Payment averages 10 days after Medicaid receives the bill.) Pharmacists would not have to retrieve drug costs to bill.
3. Bring payments up to other payors. Only 3 Medicaid states use AAC. Blue Cross/Blue Shield of Michigan switched to EAC screens at AWP-12% to -14% for independents & AWP-14% to -17% for chains.	3. Because our current payment files are keyed on Medicaid drug codes instead of NDCs, estimating the cost impact of EAC is problematic. Evaluation should be done after NDC implementation.
4. Lower department audit costs.	4. Audit activities will not decrease. Audits will focus on validating dispensing and on pharmacy coding errors when billing one drug under another's NDC.

CONCLUSIONS

- If the legislature considers Estimated Acquisition Cost (EAC), the department recommends implementation be budget neutral.
- The cost implications of EAC cannot accurately be evaluated now, because the department is in the middle of converting its 4,200 Medicaid drug codes to 60,000 National Drug Code (NDCs). EAC cost studies based on the 4,200 codes would be misleading.
- Any EAC system could only be accomplished after the department completes NDC conversion and sufficient NDC data can be collected. NDCs will be done during first quarter of FY-95. Therefore, July 1, 1995 is the earliest date that EAC implementation could occur.
- If EAC is implemented, Health Care Financing Administration approval is required.
- Invoice processing changes may be required depending on the complexity of an approved EAC. Payment time of 10 days on average will not be affected if EAC is implemented.
- Department audit activities will not decrease if EAC is implemented. Audits will focus on validating dispensing and on coding errors by pharmacies.

GLOSSARY

Actual Acquisition Cost (AAC) Reimbursement
Pharmacy payment based at the *actual invoice cost* for a drug product to the pharmacy (or its company, organization, corporation, or affiliate). Except for a 2% allowance for cash discounts, actual acquisition cost must reflect trade and quantity discounts, rebates, free goods, and price concessions.

Average Wholesale Price (AWP)
AWP is a nationally published list price used by wholesalers who sell to pharmacies. AWPs can be obtained through various national pricing services, such as, Redbook, First DataBank, and Medispan. Procurement costs are based on a discounted price off AWP or wholesaler acquisition costs plus a percent. It is for this reason that pharmacists often refer to AWP as Artificial Wholesale Price.

Estimated Acquisition Cost (EAC) Reimbursement
A pharmacy insurer estimates drug cost and pays that estimate without further documentation of the pharmacist's actual cost. In other words, pharmacies are *guaranteed the EAC price regardless of the cost of the drug.*

Manufacturer Direct Price
For selected product lines, pharmacies can purchase products directly from the manufacturer. Costs for these purchases are based on manufacturer direct prices.

Medicaid Drug Codes
Medicaid drug codes are drug identification codes used only in Michigan Medicaid. There are nearly 4,200 Medicaid drug codes. On the other hand, there are about 60,000 NDCs for these 4,200 codes. This difference occurs because under Medicaid drug codes sole-source drugs have one code for all sizes and multi-source generics have one code regardless of how many manufacturers exist. Medicaid is currently converting to NDCs. Implementation is targeted for first quarter of FY-95.

National Drug Codes
NDCs are drug identification codes used by most payors across the nation. An NDC is set for every product by manufacturer and by purchase size (e.g., bottles of 100s, 250s, etc.).

Usual & Customary Charge
Usual & customary charge is the price a pharmacy charges to the general public for a prescription.

Wholesaler Acquisition Cost (WAC)
WAC is the price a manufacturer sells a drug to wholesalers.

Attachment 1: MICHIGAN MEDICAID PHARMACY TREND
Fiscal Years 1984 - 1993

FY	Scripts	Total Rx $	Avg Script Paid	Recips W/Rxs	Manufacturer Rebate Payments	Rebate Adjusted Rx Payments (with % Change)	Adjusted Rx $'s Per Recipient (with % Change)
84	9,496,772	$86,822,120	$9.14	764,048	$0	$86,822,120	$114
85	9,577,557	$98,701,442	$10.31	723,152	$0	$98,701,442 14%	$136 20%
86	9,807,882	$115,144,530	$11.74	734,545	$0	$115,144,530 17%	$157 15%
87	10,294,129	$129,397,205	$12.57	731,462	$0	$129,397,205 12% 3/	$177 13%
88	10,406,560	$139,447,906	$13.40	731,246	$0	$139,447,906 8% 4/	$191 8%
89	10,837,699	$157,341,278	$14.52	739,644	$0	$157,341,278 13%	$213 12%
90	11,214,750	$178,970,752	$15.96	764,171	$0	$178,970,752 14%	$234 10%
91	12,254,514	$215,083,652	$17.55	819,370	$23,322,000 1/	$191,761,652 7%	$234 -0.1%
92	12,404,149	$234,253,406	$18.89	829,616	$47,394,750	$186,858,656 -3% 5/	$225 -4%
93	12,905,332	$265,156,917	$20.55	855,328	$54,225,600 2/	$210,931,317 13%	$247 9%

Legend Key to Footnotes on Data

1/ Rebate Payments Only Effective 3 Quarters
2/ Manufacturer rebates are estimated for the 4th quarter of FY-93
3/ 4/87 Started AWP - 8% Screen for Actual Acquisition Cost
4/ 3/88 Started AWP - 10% Screen for Actual Acquisition Cost
5/ 11/91 and 12/91 Started $1 Copay and PA for DAWs (Brandname Counterparts)

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Attachment 2

MICHIGAN MEDICAID PHARMACY PAYMENTS BY PRODUCT TYPE

Dates of Service October, 1992

Product Type	Prescriptions		Product Charges		Total Paid		Avg Prod Chgs
MULTI-SOURCE DRUGS		62%		32%		35%	$11.08
Misc. Medical Supplies	24,427	2%	307,625	2%	271,809	1%	$12.59
Generics *	455,079	43%	2,015,283	11%	3,184,580	15%	$4.43
Brand Counterparts *	138,142	13%	2,550,672	14%	2,899,777	14%	$18.46
Cross-Licensed	40,968	4%	850,081	5%	944,411	5%	$20.75
SOLE-SOURCE DRUGS	313,738	30%	11,539,418	63%	12,245,628	60%	$36.78
UNCLASSIFIED	81,752	8%	884,813	5%	1,034,797	5%	$10.82
TOTAL ALL PRODUCTS	1,054,106	100%	18,147,893	100%	20,581,002	100%	$17.22

Prepared 2-10-94/sjk

Attachment 3: Drug Reimbursement Methods By State - 1992

State	Dispensing Fee Min	Dispensing Fee Max *	Product Cost Reimbursement Method Lower of:	
Alabama	$5.40		Wholesale Acquisition Cost+9.2%	
Alaska	$3.45	$11.46	Avg Wholesale Price-5%	
Arkansas	$4.51		Avg Wholesale Price-10.5%	
California	$4.05	$4.05	Avg Wholesale Price-5%	
Colorado	$4.08	$4.08	Avg Wholesale Price-10%	Wholesale Acquisition Cost+18%
Connecticut	$4.10		Avg Wholesale Price-8%	
Delaware	$3.65		Avg Wholesale Price-6%	Actual Acquisition Cost
DC	$4.50		Avg Wholesale Price-10%	
Florida	$4.23		Wholesale Acquisition Cost+7%	
Georgia	$4.41		Avg Wholesale Price-10%	
Hawaii	$4.67		Avg Wholesale Price-10.5%	
Idaho	$4.30		Avg Wholesale Price	
Illinois	$3.58		Avg Wholesale Price-10%	
Indiana	$4.00		Avg Wholesale Price-10%	
Iowa	$4.02	$6.25	Avg Wholesale Price-10%	
Kansas	$3.85	$6.97	Avg Wholesale Price-10%	
Kentucky	$4.75		Avg Wholesale Price-10%	
Louisiana	$5.30		Avg Wholesale Price-10.5%	
Maine	$3.35		Avg Wholesale Price-5%	
Maryland	$4.94	$6.17	Wholesale Acquisition Cost+10%	
Massachesetts	$4.06		Wholesale Acquisition Cost+10%	
Michigan	$3.72		Avg Wholesale Price-10%	Actual Acquisition Cost
Minnesota	$4.10		Avg Wholesale Price-10%	
Mississippi	$4.91		Avg Wholesale Price-10%	
Missouri	$4.09		Avg Wholesale Price-10.43%	
Montana	$2.00	$4.08	Avg Wholesale Price-10%	
Nebraska	$2.84	$5.05	Wholesale Acquisition Cost+12.52%	Avg Wholesale Price-8.71%
Nevada	$4.42		Avg Wholesale Price-10%	
New Hampshire	$3.25	$3.65	Avg Wholesale Price-10%	
New Jersey	$3.73	$4.07	Avg Wholesale Price	Avg Wholesale Price-6%
New Mexico	$4.00		Avg Wholesale Price-10.5%	
New York	$2.60		Avg Wholesale Price	
North Carolina	$5.60		Avg Wholesale Price-10%	
North Dakota	$4.25		Avg Wholesale Price-10%	
Ohio	$3.23		Avg Wholesale Price-7%	
Oklahoma	$5.10		Avg Wholesale Price-10.5%	
Oregon	$3.67	$4.02	Avg Wholesale Price-11%	Actual Acquistion Cost
Pennsylvania	$3.50		Avg Wholesale Price	
Rhode Island	$3.40		Avg Wholesale Price	
South Carolina	$4.05		Avg Wholesale Price-9.5%	
South Dakota	$4.75		Avg Wholesale Price-10.5%	
Tennessee	$3.91		Avg Wholesale Price-8%	
Texas	$4.41		Avg Wholesale Price-10.49%	
Utah	$3.90	$4.40	Avg Wholesale Price-12%	
Vermont	$4.25		Avg Wholesale Price-10%	
Virgina	$4.40		Avg Wholesale Price-9%	
Washington	$3.65	$4.50	Avg Wholesale Price-9%	
West Virginia	$2.75		Avg Wholesale Price	
Wisconsin	$4.69		Avg Wholesale Price-10%	
Wyoming	$4.70		Avg Wholesale Price-11%	

* Variable Fees may set by the cost of the script or by size of pharmacy.